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Attachment 4.19-A
Part I

Section 86-1.5 Generally accepted accounting principles. The completion of the financial and statistical report forms shall be in accordance with generally accepted accounting principles as applied to the medical facility, unless the reporting instructions authorize specific variation in such principles.

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Section 86-1.6 Accountant's certification. (a) The financial and statistical reports shall be certified by an independent licensed public accountant or an independent certified public accountant. The minimum standard for the term independent shall be the standard used by the State Board of Public Accountancy.

(b) The requirements of subdivision (a) of this section shall apply to medical facilities operated by units of government of the State of New York heretofore exempt from the requirements of this section. Certification of reports from these facilities will be required effective with report periods beginning on or after January 1, 1977.

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Section 86-1.7 Certification by operator, officer or official.

(a) The financial and statistical reports shall be certified by the operator of a proprietary medical facility, an officer of a voluntary medical facility, or the public official responsible for the operation of a public medical facility.

(b) The form of the certification required in subdivision (a) of this section shall be as prescribed in the annual fiscal and statistical report forms provided by the State Commissioner of Health.

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Section 86-1.8 Audits. (a) All fiscal and statistical records and reports shall be subject to audit. All underlying books, records and documentation which formed the basis for the fiscal and statistical reports, filed by the medical facility with the department, shall be kept and maintained by the facility for a period of time not less than six years from the date of filing or the date upon which the fiscal and statistical records were to be filed, whichever is the later date. In this respect, any rate of payment certified or established by the State Commissioner of Health prior to audit shall be construed to represent a provisional rate until such audit is performed and completed, at which time such rate or adjusted rate will be construed to represent the audited rate.

(b) Subsequent to the filing of fiscal and statistical reports, field audits shall be conducted of the records of medical facilities in a time, manner and place to be determined by the State Department of Health. Where feasible, the department shall enter into an agreement to use a combined audit (Medicare/Medicaid and other organizations and agencies having audit responsibilities) to satisfy the department's auditing needs. In this respect, the State Department of Health reserves the right, after entering into an agreement to use a combined audit, to reject the audit findings of other organizations and agencies having audit responsibilities and to perform a limited scope or comprehensive audit of their own for the same fiscal period audited by the organization and/or agency.

(c) The required fiscal and statistical reports shall be subject to audit for a period of six years from the date of their filing with the department or from the date when due, whichever is later. This limitation shall not apply to situations in which fraud may be involved, or where the provider or an agent thereof prevents or obstructs the commissioner from performing an audit pursuant to this section.

(d) Upon completion of the audit, the medical facility shall be afforded a closing conference. The medical facility may appear in person or by anyone authorized in writing to act on behalf of the medical facility. The medical facility shall be afforded an opportunity at such conference to produce additional documentation in support of any modifications requested in the audit.

(e) The medical facility shall be provided with the audit report and the rate computation sheet per audit. The audit report shall be final unless within 30 days of receipt of the audit report, the medical facility initiates a bureau review of such final audit report by notifying the Division of Health Care Financing by registered or certified mail, detailing the specific items of the audit report with which the provider disagrees, and such other material as the provider wishes to submit in its behalf, and forwarding all material documentation in support of the medical facility's position.

(f) The medical facility shall be notified in writing of the determination of the controverted items of the final audit report, including a statement of the reasons for such adjustments and the appropriate action to applicable law, regulation or policy. The audit

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findings as adjusted in accordance with the determination of the bureau review shall be final, except that the medical facility may, within 30 days of receipt of the determination of the bureau review, initiate a hearing to refute those items of the audit report adverse to the interests of the medical facility presenting a factual issue by serving on the commissioner, by certified or registered mail, a notice containing a statement of the legal authority and jurisdiction under which the hearing should be held, a reference to the particular sections of the statutes and rules involved and a statement of the controverted items of the audit report and bureau determination, together with copies of any documentation relied on by the medical facility in support of its position.

(1) Upon receipt of such notice the commissioner shall:

(i) designate a hearing officer to hear and recommend;

(ii) establish a time and place for such hearing;

(iii) notify the medical facility of the time and place of such hearing at least 15 days prior thereto; and

(iv) include in a notice of hearing those issues of the audit report which are controverted in the notice served on the commissioner by the medical facility.

(2) The issues and documentation presented by the medical facility at such hearing shall be limited to the factual issues and documentation presented at the bureau review.

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(3) The audit report shall be presumptive evidence of its content. The burden of proof at any such hearing shall be upon the medical facility to prove by substantial evidence that the items therein contained are incorrect.

(4) The hearing shall be conducted in conformity with section 12-a of the Public Health Law and the State Administrative Procedure Act.

(5) At the conclusion of the hearing the medical facility may submit memoranda on any legal issues which it deems relevant to the proceeding. Such memoranda shall become part of the official record of the hearing.

(g) Rate revisions resulting from the procedure set forth in this section shall be made retroactive to the period or periods during which the rates based on the periods audited were established. Any resulting overpayment or underpayment shall be satisfied by either retroactive adjustment of the provisional rate paid, based on the period audited, or prospective adjustment of the current certified rate at the discretion of the State Commissioner of Health.

(h) [All overpayments resulting from rate revisions shall be subject to such penalties as the Commissioner of Health may impose for

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the incorrect completion of the report or the failure to file required revisions of the report in the amount of up to 25 percent of the overpayment for negligent incorrect completion or negligent failure to file revisions and up to 100 percent of the overpayment for willful incorrect completion or willful failure to file revisions. The penalties assessed under this section are separate from and shall not be construed to be in mitigation of damages which may be recovered pursuant to section 145-b of the Social Services Law.] reserved.

(i) Notwithstanding the provisions of this section, the commissioner may promulgate rate revisions based on audits completed by another State agency. Unless otherwise indicated, such audits shall not be considered final and shall not prelude conduct of a complete audit by the State Department of Health or its agent.

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Section 86-1.9 Patient days. (a) A patient day is the unit of measure denoting lodging provided and services rendered to one inpatient ~~between the census-taking hour on two successive days.~~

(b) In computing patient days, the day of admission shall be counted but not the date of discharge. When a patient is admitted and discharged on the same day, this period shall be counted as one patient day.

(c) For reimbursement purposes, three newborn days shall be reported as the equivalent of one adult or child day. The following types of care shall not be treated as being rendered to newborns for patient day calculations: premature infant, newborn remaining in hospital after mother's discharge, sick infant care requiring general hospital service, and infant care to those born outside the hospital and not placed in the newborn nursery.

(d) For reimbursement purposes, patient days for medical/surgical, pediatrics, and maternity shall be computed as follows:

(1) Medical-surgical patient days for facilities located in counties having an average population density of 100 or more persons per square mile shall be determined by using the higher of the minimum utilization factor of 85 percent of certified beds or actual patient days of care furnished by the facility. Medical-surgical patient days for facilities located in counties having an average population density of less than 100 persons per square mile shall be determined by using the higher of the minimum utilization factor of 80 percent of certified beds or actual patient days of care furnished by the facility.

(2) Pediatric patient days shall be determined by using the higher of the minimum utilization factor of 70 percent of certified beds or actual patient days of care furnished by the facility.

(3) Maternity patient days for facilities located in areas having a plan approved by the commissioner for the regionalization of obstetrical service, and subsequent to January 1, 1978 for all facilities including those services in areas not having an approved plan shall be determined as follows:

(i) Maternity patient days for facilities in counties with an average population density of 100 or more persons per square mile shall be determined by using the lower of the minimum utilization factor of 75 percent of certified beds or, if the facility generated less than 1,500 live births, the difference between 1,500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or, if the facility generated more than 1,500 live births, the actual days of care furnished by the facility.

(ii) Maternity patient days for facilities in counties with an average population density of less than 100 persons per square mile shall be determined by using the lower of the minimum utilization factor of 60 percent of certified beds or, if the facility generated less than 500 live births, the

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difference between 500 and the actual number of live births generated by the facility multiplied by the average length of stay for a maternity patient plus the actual days of care furnished by the facility or if the facility generated more than 500 live births, the actual days of care furnished by the facility.

(iii) Maternity service patients for purpose of computations pursuant to subparagraphs (i) and (ii) of this paragraph shall include obstetrical and gynecological patients housed in the maternity unit.

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(4) The provisions of paragraphs (1) and (2) of this subdivision shall be waived in total or in part by the Commissioner of Health in those cases where waiver has been demonstrated to be a matter of public interest and necessity. Where a facility could reach its minimum utilization factor by reducing the certified bed capacity by more than five beds or one percent of its certified bed complement, whichever is greater, the commissioner may grant a waiver only if the facility decertifies the total number of beds necessary to reach the minimum utilization factor. Where the minimum bed utilization factor would be reached by decertifying no greater than five beds or one percent of its certified bed complement, a waiver shall be granted and decertification of beds shall not be required.

(5) The provisions of paragraph (3) of this subdivision shall be waived by the Commissioner of Health in those cases wherein there is an approved regional plan and wherein the service in question, its capacity and operation are consistent with the approved regional plan. The provisions of paragraph (3) of this subdivision may be waived by the commissioner where it is a matter of public interest and necessity; if such a waiver is granted, maternity patient days shall be determined by using the higher of the applicable minimum utilization factor or live birth formula as set forth in paragraph (3) of this subdivision.

(6) The provisions of paragraphs (1) - (3) of this subdivision shall be waived for rural hospitals as defined in this Title.

(7) No waiver pursuant to this subdivision shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of the request and justification for the waiver, and fulfillment of conditions to the waiver, where such conditions exist.

(e) For reimbursement purposes, patient days for open heart surgery, cardiac invasive diagnostic procedures and kidney transplants shall be computed as follows for those facilities engaged in such operations and procedures:

(1) Patient days for any facility engaged in performing open heart surgery and carrying out less than 100 adult and/or 50 pediatric (less than age 21) operations during the reporting period shall be increased by an amount equal to the average length of stay for the adult and/or pediatric open heart surgery cases multiplied by the difference between 100 adult or 50 pediatric and

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the actual number of adult or pediatric open heart surgery operations carried out by the approved cardiac surgical center as referenced in Part 405 of this Title.

(2) Patient days for any facility engaged in performing adult or pediatric (less than 21) cardiac invasive diagnostic procedures and carrying out less than 200 adult and/or 100 pediatric procedures during the reporting period shall be increased by an amount equal to the average length of stay for the adult or pediatric procedures multiplied by the difference between 200 adult and/or 100 pediatric cardiac invasive diagnostic procedures and the actual number of procedures carried out by the approved cardiac diagnostic center as referenced in Part 405 of this Title.

(3) Patient days for any facility engaged in kidney transplants and carrying out less than 25 such transplants during a reporting period shall be increased by an amount equal to the average length of stay for kidney transplants multiplied by the difference between 25 and the actual transplants carried out by the facility.

The provisions of this subdivision may be waived by the State Commissioner of Health upon application by the health facility in those cases where waiver is found to be a matter of public interest and necessity. No waiver shall be granted for periods predating the first day of the month following 30 days after receipt by the commissioner of request and justification for the waiver.

(f) Patient days for all alternate level of care (ALC) services shall be reported separately. Patient days for alternate level of care services shall be utilized in the determination of minimum utilization standards as set forth in section 86-1.9(d) of this Subpart.

(g) For rate year 1985 hospitals located in an HSA region where the average daily medical/surgical occupancy is less than the appropriate minimum utilization factor set forth in paragraph (1) of subdivision (d) of this section and the hospital itself has an average daily medical/surgical occupancy of less than the appropriate minimum utilization factor set forth in paragraphs (1) and (4) of subdivision (d) of this section and the hospital provides alternate level of care services, the hospital's title XIX rate shall be reduced by the difference between its title XIX rate and the facility's allowable routine cost as determined pursuant to this Subpart and a statewide average of allowable ancillary costs for hospital-based skilled nursing or health related facilities, as appropriate to the level of care actually provided to the patient and as determined pursuant to Subpart 86-2 of this Title. Beds for which a facility has applied for decertification by January 31, 1986 and which are decertified by the commissioner shall not be counted in the calculation of occupancy rates for the purposes of this subdivision. The provisions of this subdivision shall be waived for hospitals which in 1985 meet the definition of rural hospital set forth in section 405.2(m) of this Title and which are not identified as unnecessary in the state and regional medical facilities plan established pursuant to section 710.13 of this Title.

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